Michigan Department of Community Health

DRAFT HIPAA 5010A1 EDI Companion Guide for ANSI ASC X12N 837P Health Care Claim: Professional

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Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

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Introduction

This document is the property of the Michigan Department of Community Health (MDCH). The information contained in this document is for the use of Trading Partners engaging in electronic data interchange (EDI) health care transactions with the State of Michigan's Community Health Automated Medicaid Payment System (CHAMPS).

This document is intended as a companion to the 005010X222 • 837P Health Care Claim: Professional Technical Report 3 (TR3) dated May 2006. This document also includes updates appearing in:

- Errata 005010X222E1 • 837 Health Care Claim: Professional dated January 2009
- Errata 005010X222A1 • 837 Health Care Claim: Professional dated June 2010

The TR3 documents replace the 4010A1 Implementation Guide and related Addenda. The 5010A1 TR3 and related Errata documents can be downloaded from the Washington Publishing Company web site at http://www.wpc-edi.com/content/view/817/1.

This document is expected to be used in conjunction with the TR3 and related Errata for the 837P transaction set. The content of this document follows the guidelines authorized in the version modifications to the Health Insurance Portability and Accountability Act (HIPAA) Final Rule transaction standards published in the Federal Register January 16, 2009.

This document provides MDCH-specific instructions regarding certain elements within the TR3 but does not change, supersede, or add to the definitions, data conditions, or use of data elements or segments in the standard. This document provides MDCH rules regarding:

- Identifiers to use when a national standard has not been adopted
- Parameters in the TR3 and related Errata that provide options

In order to successfully download HIPAA transactions from the CHAMPS system it is necessary to comply with the information contained in the MDCH Electronic Submission Manual Dated February 2009. Note that revision of the MDCH Electronic Submission Manual is expected during calendar year 2011. The most current version of this manual can be downloaded from the MDCH web site at the following location: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42545_42638---,00.html.

Transaction Description

This transaction set is used to exchange health care claim and/or encounter information, or both, from providers of health care services to payers including managed care organizations. This transaction can be submitted either directly or via intermediary billing services and/or claims clearinghouses.

Upload/Submission Notes for ANSI ASC X12 837P Health Care Claim: Professional

This Companion Guide is intended for use in the electronic submission for fee-for-service health care claims. Please refer to the MDCH website for Companion Guides supporting the submission of health care encounters. Claims and encounters cannot be sent on the same 837 Transaction file.

Please refer to the MDCH Electronic Submission Manual for information regarding:

- Interaction with the MDCH's Data Exchange Gateway (DEG)
- Modes of submission (FTP, SSL FTP, HTTPS, or electronic batch submission)
- Interchange Acknowledgement (TA1) transaction
- Interchange Acknowledgement (999) transaction

This document uses several text conventions to aid in the interpretation of the Companion Guide Rules. The following table lists the text conventions used in this document.

Convention used	Explanation
< >	Text included within < > is the "Implementation Name" field from the TR3 document.
" "	Text with " " around a value represents the value to be submitted. This may be a TR3 value or a specific value required by MDCH.
( )	The description of the HIPAA TR3 value in quotes, described above, is provided parenthetically.

ANSI ASC X12 837P Health Care Claim: Professional Companion Guide Rules

837P - Interchange Control Header

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Interchange Control Header	
	ISA		**Segment - Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	"00" (No Authorization Information Present (No Meaningful Information in I02))
	ISA	ISA02	Authorization Information	10 Spaces
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present (No Meaningful Information in I04))
	ISA	ISA04	Security Information	10 Spaces
	ISA	ISA05	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA06	Interchange Sender ID	Trading Partner ID For FTP, SSL FTP, or HTTPS use the DEG ID left justified, followed by spaces. For electronic batch use NPI or CHAMPS Provider ID, left justified, followed by spaces.
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	ISA	ISA08	Interchange Receiver ID	"D00111" left justified followed by spaces.
			Functional Group Header	
	GS		**Segment - Functional Group Header**	
	GS	GS02	Application Sender's Code	Trading Partner ID For FTP, SSL FTP, or HTTPS use the DEG ID. For electronic batch use NPI or CHAMPS Provider ID. This value should always match ISA06 <Interchange Sender ID>.
	GS	GS03	Application Receiver's Code	"D00111" for MDCH

837P - Transaction Set

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Transaction Set Header	
	ST		**Segment - Transaction Set Header**	**MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA mandated implementation guide. Submissions greater than 5,000 CLM segments in a single transaction will be rejected.**
	BHT		**Segment - Beginning of Hierarchical Transaction**	
	BHT	BHT06	Transaction Type Code	<Claim or Encounter Identifier> "CH" (Chargeable) for claims
1000A			**Loop - Submitter Name**	
1000A	**NM1**		**Segment - Submitter Name**	
1000A	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number (ETIN) Established by trading partner agreement)
1000A	NM1	NM109	Identification Code	<Submitter Identifier> For FTP, SSL FTP, or HTTPS use the DEG ID. For electronic batch use NPI or CHAMPS Provider ID. This value should always match ISA06 <Interchange Sender ID> and GS02 <Application Sender's Code>.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
1000B			**Loop - Receiver Name**	
1000B	**NM1**		**Segment - Receiver Name**	
1000B	NM1	NM103	Name Last or Organization Name	<Receiver Name> "Michigan Department of Community Health" or "MDCH"
1000B	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number (ETIN) Established by trading partner agreement)
1000B	NM1	NM109	Identification Code	<Receiver Primary Identifier> "D00111" for MDCH
2000B			**Loop - Subscriber Hierarchical Level**	
2000B	**SBR**		**Segment - Subscriber Information**	
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	"P" if MDCH is the only payer (patient has no Medicare or other insurance)
2000B	SBR	SBR09	Claim Filing Indicator Code	'"MC" (Michigan Medicaid)
2010BA			**Loop - Subscriber Name**	
2010BA	**NM1**		**Segment - Subscriber Name**	
2010BA	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2010BA	NM1	NM109	Identification Code	<Subscriber Primary Identifier> Patient's 10 digit beneficiary ID number assigned by MDCH.
2010BB			**Loop - Payer Name**	
2010BB	**NM1**		**Segment - Payer Name**	
2010BB	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2010BB	NM1	NM109	Identification Code	<Payer Identifier> "D00111" for MDCH
2000C			**Loop - Patient Hierarchical Level**	**MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect providers to submit any Loop - 2000C Patient Hierarchical Levels in a transaction set. Transaction sets that contain Loop - 2000C Patient Hierarchical Level information will be rejected.**
2300			**Loop - Claim Information**	**Note that the HIPAA mandated implementation guide allows a maximum of 100 repetitions of the 2300 claim information within each Loop - 2000B Subscriber Hierarchical Level. Transaction sets that do not associate Loop - 2300 Claim Information with Loop - 2000B will be rejected.**
2300	**CLM**		**Segment - Claim Information**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2300	CLM	CLM05-3	Claim Frequency Type Code	<Claim Frequency Code> "1" Original claim submissions "7" Claim replacement "8" Claim void/cancel For both "7" and "8" include the original 18-digit CHAMPS TCN (15-digit legacy CRN), as indicated in Loop - 2300 REF (Payer Claim Control Number).
2300	**REF**		**Segment - Payer Claim Control Number**	
2300	REF	REF01	Reference Identification Qualifier	"'F8" (Original Reference Number)
2300	REF	REF02	Reference Identification	<Payer Claim Control Number> Include the original 18-digit CHAMPS TCN (15-digit legacy CRN) of the previously adjudicated claim when CLM05-3 <Claim Frequency Code> indicates this claim is a replacement “7” or void "8".
2320			**Loop - Other Subscriber Information**	**If Michigan Medicaid is the primary payer, this loop should not be reported.**
2320	**SBR**		**Segment - Other Subscriber Information**	
2320	SBR	SBR03	Reference Identification	<Insured Group or Policy Number> Subscriber’s group number (assigned by the other payer), not the number that uniquely identifies the subscriber.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2320	**CAS**		**Segment - Claim Level Adjustments**	**MDCH requires all COB adjudication information to be submitted in the service line level Loop - 2430 Segment CAS - Line Adjustment.**
2330A			**Loop - Other Subscriber Name**	**Use the name of the subscriber as it appears on the files of the other payer.**
2330A	**NM1**		**Segment - Other Subscriber Name**	
2330A	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number)
2330A	NM1	NM109	Identification Code	<Other Insured Identifier> Use the unique member number assigned to the subscriber by the other payer indicated in Loop – 2330B Other Payer Name.
2330B			**Loop - Other Payer Name**	
2330B	**NM1**		**Segment - Other Payer Name**	
2330B	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2330B	NM1	NM109	Identification Code	<Other Payer Primary Identifier> For Other payers use the payer ID associated to the beneficiary within the CHAMPS eligibility record for the date of service.
2400			**Loop - Service Line Number**	**Note that the HIPAA mandated implementation guide allows a maximum of 50 repetitions of Loop - 2400 Service Line Number within each Loop - 2300 Claim Information.**

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2430			**Loop - Line Adjudication Information**	
2430	**CAS**		**Segment - Line Adjustment**	**MDCH requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer adjudication information.**

Revision Log

Version Date	Effective Date	Revision Description
February 15, 2011 (Draft)	January 1, 2012	This document replaces *Companion Guide for the HIPAA 837 Professional Claim Addenda Version 4010A1* dated September 18, 2009.